Testimony of
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Introduction

Chairman Deal, Representative Brown, distinguished members of the Subcommittee, thank you for inviting me here today to discuss our efforts to promote high-quality physicians' services for our Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) is actively engaged with both the Congress and physician community on this important topic. This is a very significant time. It is a moment when, with your leadership, we can make real progress in identifying ways to align Medicare's physician payment system with the goals of health professionals for high-quality care, without increasing overall Medicare costs. If we are able to design a payment system that aligns reimbursement with quality and efficiency, we can better encourage physicians to provide the type of care that is best suited for our beneficiaries -- care focused on prevention and treating complications; care focused on the most effective, proven treatments available. This is far preferable to the current physician payment system, which simply increases payment rates as the volume of services continues to grow rapidly.

In order to move toward this vision, CMS has supported and worked collaboratively with the physician community to develop measures that capture the quality of care being provided to our Medicare beneficiaries. We continue to support efforts to expand the available measures of physician quality, including measures of the overall cost or efficiency of care. Through the Physician Voluntary Reporting Program (PVRP), CMS is also working with the physician community to develop and gain experience with the infrastructure and methods needed to collect data on several quality measures and provide

confidential feedback to physicians based on those reports. CMS is also conducting demonstration programs designed to test a pay-for-performance system in the physician office setting that we hope will yield information helpful to the agency and the Congress as we consider options for revising the Medicare physician payment system. Throughout all of these efforts, CMS will continuously work with physicians and their leadership in an open and transparent way in order to support the best approaches to provide high quality health care services without creating additional costs for taxpayers and Medicare beneficiaries.

Physician Payment Update

Currently, updates to Medicare physician payments are made each year based on a statutory formula established in section 1848(d) of the Social Security Act. The calculation of the Medicare physician fee schedule update utilizes a comparison between target spending for Medicare physicians' services and actual spending. The update is based on comparison of cumulative targets for each year and actual spending from 1996 to the current year. If actual spending exceeds the targets, updates in subsequent years are negative until such time as spending comes into line with the targets and vice versa. The use of targets is intended to control the growth in aggregate Medicare expenditures for physicians' services.

Actual spending on physicians' services has been growing at a faster rate than target spending. For several years now, in response to this rise in spending, the statutory update formula would have operated to impose payment cuts. However, to stave off the cuts, in the Medicare Modernization Act (MMA) and Deficit Reduction Act (DRA), Congress temporarily suspended the requirements of the formula in favor of a specific, statutorily dictated update in 2004, 2005, and 2006. In passing these measures, Congress did not include a long-term modification to the underlying update formula. This resulted in actual spending that, rather than being held back, actually advanced, furthering the gap between actual spending and the targets, exacerbating the already difficult situation.

When, in 2007 and beyond, the statutory formula is reactivated under current law, it is expected to impose cuts in payments to physicians over a number of years, to bring actual spending back in line with the targets. Sustained reductions in payment rates raise real concerns about the current system's ability to ensure access to care for Medicare beneficiaries. In addition, it does not create incentives for physicians to provide the highest quality care at the lowest overall cost. For these reasons, finding better approaches for payment that do not increase overall costs remains an urgent priority.

The existing system is designed to control spending in the aggregate, but in recent years it has not been successful in limiting spending growth by influencing the behavior of individual physicians. We recently released the Mid-Session Review of the Budget. Medicare Part B expenditures are now projected to be significantly higher than budgeted, as a result of rapid growth in the use of both physician-related services and hospital outpatient services. The main reason for the 10 percent growth in expenditures for physicians' services in 2005 is an increase in the volume and intensity of services. Increases in the volume and intensity of physicians' services are estimated to be 7 percent for 2005, and are projected to be 6 percent for 2006. The continuing rapid growth in utilization and thus in Part B spending has two important consequences: it will lead to substantial increases in Part B premiums, and will increase the difference between actual and target expenditures with the existing update formula.

Furthermore, the increases in volume and intensity do not appear to be driven primarily by evidence-based changes in clinical practices. And with reductions in payment rates when volume rises, some health care providers may feel more pressure to increase volume in order to sustain revenues. This sort of behavior is precisely what we do not want. There is already substantial evidence of overuse, misuse, and underuse of medical treatments that results in potentially preventable complications and higher costs. Yet by paying more for more treatments, regardless of their quality or impact on patient health, our current system does little to address these quality problems and in certain respects could support and encourage less than optimal care. Instead, we should be paying for care in a way that encourages improved quality and keeps overall costs down. Fully

addressing this situation will require legislative action by the Congress. The Administration looks forward to working with the Congress as it explores a budget-neutral legislative resolution to this challenge, but CMS believes that any new payment system must emphasize quality and appropriateness of care, as opposed to paying more for higher volume and intensity.

Developing Quality Measures

The physician community understands the urgency of revising Medicare's payment system, and for some time now, supported by CMS, has been engaged in efforts to develop useful, agreed upon measures of quality care. Quality measures are the basic foundation and pre-requisite for a payment system that encourages physicians in their efforts to provide the most clinically appropriate care, rather than the most volume.

For several years, CMS has been collaborating with a variety of stakeholders to develop and implement uniform, standardized sets of performance measures for various health care settings. In the past year, thanks to the leadership of many physician organizations, these efforts have accelerated even further.

Our work on the quality measures has been guided by the following widely-accepted principles. Quality measures should be evidence-based. They should be valid and reliable. They should be relevant to a significant part of medical practice. And to assure these features, quality measures should be developed in conjunction with open and transparent processes that promote consensus from a broad range of health care stakeholders. It also is important that quality measures do not discourage physicians from treating high-risk or difficult cases, for example, by incorporating a risk adjustment mechanism when needed. In addition, quality measures should be implemented in a realistic manner that is most relevant for quality improvement in all types of practices and patient populations, while being least burdensome for physicians and other stakeholders.

There are several distinct steps pertaining to the implementation of physician quality measures, including: 1) development through a standardized process; 2) consensus

endorsement of measures as valid, usable, important, and feasible; and 3) consensus endorsement of measures for use in the healthcare market.

Development through a standardized process. There are a limited number of experienced physician quality measure developers. These include the American Medical Association's Physician Consortium for Performance Improvement (AMA-PCPI), the National Committee for Quality Assurance (NCQA), and some physician specialty societies. Most of the physician measurement development work prior to 2006 pertained to primary care specialties.

Consensus measure endorsement. Once measures are developed, it is still necessary to achieve a broader consensus on their validity, usability, and importance as a measure of healthcare quality. The National Quality Forum plays a significant role in this process. Most of the NQF endorsed measures as of 2006 relate to ambulatory care and therefore primary care specialties.

Consensus for use in healthcare marketplace. There is an additional need for consensus on measures for practical use in the marketplace. This is to promote uniformity by payers and purchasers in implementing quality reporting programs for physicians that have the maximum impact on improving quality and avoiding unnecessary costs. Without this consensus, physicians could not only be burdened by dealing with numerous sets of measures for numerous payers, but also the results themselves would suffer by the small number of patients that any individual payer would represent for a particular physician practice. This consensus-building role is fulfilled by the Ambulatory Care Quality Alliance (AQA). The AQA in April, 2005 endorsed a 26 measure starter set of measures pertaining to primary care specialties. In 2006, the AQA is focusing on adding non-primary care specialties to its consensus measures.

Implementation for reporting. Implementation of measures requires additional considerations, particularly the method of clinical data reporting. Generally, physician claims do not include all the clinical data required for physician quality measurement.

Physicians and payers do not necessarily have interoperable electronic health records that have potential for automating the process of data gathering either. As a result, any method of quality measure reporting should build on existing claims reporting systems if it is to be successful in the near future. The AQA has a specific workgroup that focuses on developing consensus in reporting, and CMS is supporting efforts by the AQA, AHIC, and others to assure that interoperable electronic health records systems will support more automated collection and reporting of consensus measures as they become available.

Examples of Quality Measures

Examples of three ambulatory quality measures are based on the results of the hemoglobin A1C and LDL and blood pressure tests for diabetic patients. The clinical evidence suggests that patients who have a hemoglobin A1C test below 9 percent, an LDL less than or equal to 100 mg/dl, and blood pressures less than or equal to 140/80 mmHg have better outcomes. These measures are evidence-based, reliable and valid, widely accepted and supported, and were developed in an open and transparent manner. Evidence indicates that reaching these goals can lead to fewer hospitalizations by avoiding complications from diabetes such as amputation, renal failure, and heart disease.

Two quality measures endorsed by the National Quality Forum (NQF) for heart failure patients include placing the patient on blood pressure medications and beta blocker therapy. Here too, these therapies have been shown to lead to better health outcomes and reduce preventable complications. Together, diabetes and heart failure account for a large share of potentially preventable complications.

In addition to primary care quality measures, other specialties are developing measures. For example, measures of effectiveness and safety of some surgical care at the hospital level have been developed through collaborative programs like the Surgical Care Improvement Program (SCIP), which includes the American College of Surgeons. Preventing or decreasing surgical complications can result in a decrease in avoidable hospital expenditures and use of resources, and more important, avoiding complications

improves the health, functioning, and quality of life of Medicare beneficiaries. For example, use of antibiotic prophylaxis has been shown to have a significant effect in reducing post-operative complications at the hospital level. This particular measure is well developed and there is considerable evidence that its use could not only result in better health but also avoid unnecessary costs. This post-operative complication measure, which is in use in our Hospital Quality Initiative, is being adapted for use as a physician quality measure. Application of this type of post-operative complication measure at the physician level has the potential to help avoid unnecessary costs as well as improve quality.

We also are collaborating with other specialty societies, such as the Society of Thoracic Surgeons (STS), to implement quality measures that reflect important aspects of the care of specialists and sub-specialists. The STS has already developed a set of 21 measures at the hospital level that are risk adjusted and track many common complications as outcome measures. STS is also conducting a national pilot program to measure cost and quality simultaneously, while communicating quality and efficiency methods across regional hubs with the objective of reducing unnecessary complications and their associated cost. The STS measures have been adapted to a set of five quality measures for physicians, such as for a patient who receives by-pass surgery with use of internal mammary artery. Many other specialties have also taken steps to develop evidence-based quality measures.

The Physician Voluntary Reporting Program

As a first step toward aligning Medicare's physician payment system with the goals of quality improvement, CMS launched the PVRP in January 2006. The goals of the PVRP include: 1) developing methods for collecting data submitted by physicians' offices on the quality measures; and 2) providing physicians' offices with confidential feedback reports detailing their performance rate and reporting rates on applicable measures. CMS anticipates that this effort will provide the agency and the physician community with experience in gathering data on quality and help us better understand what may be required in moving toward a system that rewards quality care, not simply volume of care.

PVRP Quality Measures

When CMS conceived of the PVRP the agency decided to draw on measures of quality previously developed in collaboration with the physician community, including efforts by the American Medical Association's Physician Consortium for Performance Improvement (AMA-PCPI), the National Committee for Quality Assurance (NCQA), and other physician specialty societies. Where there were no measures to address specialty services, the PVRP incorporated adaptable measures endorsed by the NQF. We are working closely with various parties, including the Ambulatory Quality Alliance (AQA), to expand the initial set. We anticipate that this cooperative effort, culminating in endorsement by the AQA of an expanded set of measures, will continue to expand the scope of covered services. CMS expects that physicians will continue to be the leaders in the development of performance measures for the various specialties. They are in the best position to understand which measures will represent high quality care and have a significant impact if made available and used within their profession. As they do so, we will be able to incorporate them into the PVRP.

There are currently 16 quality measures in the PVRP. When selecting the 16 measures, preference was given to measures that were endorsed by both the NQF and AQA and that collectively covered a broad range of medical specialties and did not add undue burden to physicians. CMS is working to expand the PVRP measure set beyond the 16 to cover medical specialties that account for the majority of Medicare payments. We anticipate an expanded set of PVRP measures this fall that physicians can report during the first quarter of 2007. In that effort we are continuing to work with the physician community. The Alliance of Specialty Medicine, for example, has provided CMS with feedback on the implementation of the PVRP pilot program, and has been working closely with its members to develop additional quality improvement and performance measures for the future expansion of the PVRP program. In that effort to expand available measures, CMS focused on those measures subject to the standardized measure development process, and consensus endorsement through AQA and NQF. In addition, CMS entered a contract with Mathematica in September, 2005 to develop physician specialty measures.

Mathematica chose the AMA and the NCQA as sub-contractors for this work that is being carried out through the AMA-PCPI process.

PVRP Data Collection

The usual source of clinical data for quality measures is retrospective chart abstraction but this process is costly and burdensome to physicians' offices. As a result, the PVRP was designed to enable physicians' offices to submit quality measures data through the pre-existing administrative claims submission process. Specifically, physicians can submit a predefined set of Healthcare Common Procedure Coding System (HCPCS) codes, commonly referred to as the G-codes, to report data on the PVRP measures. When a physician determines that a particular measure is applicable to the work he or she does, the PVRP is designed to allow use of a single G-code to report on that measure, thus minimizing the burden on the physician.

We anticipate that the use of G-codes to report on the PVRP quality measures will be reasonably straightforward while avoiding the burden of chart abstraction. For example, the HCFA-1500 form currently used by all physicians for Medicare billing purposes (and by many private payers as well) is being used to report the PVRP G-codes, paralleling the process physicians have been using for years to report and bill for the medical services they provide.

The AMA has designed CPT Category II codes based upon this same principle of utilizing the pre-existing administrative claims process. These codes are supplementary tracking codes used for measurement of clinical performance measures, rather than for reporting specific procedures performed in the treatment of a patient. Where available, CMS has incorporated CPT Category II codes for use in the PVRP.

The use of G-codes on the pre-existing administrative claims form is an interim reporting mechanism until electronic submission of clinical data through electronic health records (EHR) is more widely available. EHR will greatly facilitate clinical data reporting by physicians' offices in the future but its adoption is not widespread. CMS is currently able

to accept the electronic submission of data for primary care physicians and we are working with EHR vendors to expand acceptance of electronic data beyond primary care. CMS is also exploring the possibility of leveraging pre-existing data base registries. One such registry that CMS is actively exploring is the one developed by the Society of Thoracic Surgeons.

PVRP Feedback to Physicians

One of the purposes of the PVRP is to assist physicians with their own quality improvement goals. Therefore, CMS will be providing physicians' offices the opportunity to receive confidential feedback reports. These reports will be first available in December 2006 and will contain the performance and reporting rates for the PVRP quality measures for which that office submitted data. CMS hopes that such information will provide physicians' offices with the guidance they need to implement their own internal quality improvement programs.

CMS will also be working collaboratively with the physician community in order to gauge the utility and relevance of the information provided to them in the confidential feedback report. CMS anticipates working with physicians to ensure that the confidential feedback report provides information that is deemed useful, complete, and accurate.

In addition to the provider feedback report, CMS is reaching out to physician communities on many other levels to ensure that they receive needed information and support. A few of the activities that CMS has undertaken include:

1) Local level support through the CMS Regional Offices
2) PVRP email address for questions at PVRP@cms.hhs.gov
3) Informational website support, including Frequently Asked Questions (FAQs), at www.cms.hhs.gov/PVRP
4) PVRP Community collaborative website, to be released in early August 2006. The PVRP Collaborative website will allow participants the opportunity to utilize discussion threads to provide input or seek answers from other participants, including sharing of best practices or lessons learned.

5) Help Desk support for the registration process and PVRP Community collaborative website. The Help Desk is available for support from 7 am – 7 pm (CST) at (866) 288-8912

CMS finds the information provided by the physician community to be very valuable and will continue to explore other venues to offer the physician community the information and support that they need.

Quality Based Payment System

CMS does not have the statutory authority to implement a quality-based payment system. However, the PVRP initiative will give us an opportunity to educate ourselves and our physician partners about what is needed to set up a quality data gathering and reporting system that works best for our patients and that is least burdensome to the participating physicians. We also hope to provide useful information to physicians' offices that will assist them with their professional quality improvement goals. We will continue working with the physician community to increase the number of available measures so that physicians of all specialties will have a set of measures applicable to the work that they do. We are pleased that at this point we have almost 6,400 physicians who have indicated a willingness to participate in the PVRP. Though we would like to see this number continue to increase, the current number of participants is adequate for testing our quality measures reporting infrastructure

Demonstration Projects Focused on Quality

In addition to the PVRP, demonstration projects being undertaken by the Agency are designed to help us understand how to use our payment systems to encourage quality care by our physician partners.

The Physician Group Practice Demonstration

In early 2005, CMS announced the Physician Group Practice (PGP) demonstration. This demonstration is designed to encourage physician groups to coordinate their care to chronically ill beneficiaries, give incentives to groups that provide efficient patient

services, and promote active use of utilization and clinical data to improve efficiency and patient outcomes.

Many physician practices and other supportive practices can lead to better patient outcomes and lower overall health care costs. For example, there is good evidence that by anticipating patient needs, especially in those patients with chronic diseases, health care teams that partner with patients and coordinate across physician practices can help implement physicians' plans of care more effectively, reducing the need for expensive procedures, hospitalizations for preventable complications and perhaps even some office visits. Medicare's current payment system reimburses physicians based on the number and complexity of specified services and procedures that they provide, not how physicians work together to avoid problems in the first place.

Medicare is now testing whether performance-based payments for physicians under the demonstration result in better care. The PGP demonstration is the first value-based purchasing initiative for physicians under Medicare. The PGP demonstration rewards physicians for improving the quality and efficiency of health care services delivered to Medicare fee-for-service beneficiaries. Mandated by Section 412 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the PGP Demonstration seeks to:

- encourage coordination of Part A and Part B services,
- promote efficiency through investment in administrative structure and process, and
- reward physicians for improving health outcomes.

The demonstration is allowing CMS to test physician groups' responses to financial incentives for improving care coordination, delivery processes and patient outcomes, and the effect on access, cost, and quality of care to Medicare beneficiaries.

Physician groups participating in the demonstration are paid on a fee-for-service basis. However, they will implement care management strategies designed to anticipate patient

needs, prevent chronic disease complications and avoidable hospitalizations, and improve quality of care. To the extent they implement these strategies effectively to improve care, physician groups will be eligible for additional performance payments derived from any savings that are achieved through improved care coordination for an assigned beneficiary population.

Performance targets will be set annually for each group based on the growth rate of Medicare spending in the local market. Performance payments may be earned if actual Medicare spending for the population assigned to the physician group is below the annual target. Performance payments will be allocated between efficiency and quality, with an increasing emphasis placed on quality during the demonstration. The demonstration is required by law to be budget neutral.

CMS selected ten physician groups on a competitive basis, representing some 5,000 physicians with over 200,000 Medicare fee-for-service beneficiaries, to participate in the demonstration. The groups were selected based on a variety of factors including technical review panel findings, organizational structure, operational feasibility, geographic location, and demonstration implementation strategy. The groups will be implementing a variety of methods for improving quality and CMS will measure and evaluate the results of each.

Below are preliminary examples of quality and efficiency innovations being put into place by two of the groups participating in CMS' PGP demonstration. Please note that references to results in these examples are based on the organizations' information and not official CMS demonstration results. Therefore, the references should be considered with caution and not interpreted as conclusive.

1. Disease Management Strategies

Park Nicollet Health Services (PNHS) is redesigning its care processes for patients with congestive heart failure and diabetes. Through the use of nurse case managers and information technology, over 600 congestive heart failure patients are monitored daily in

order to identify patients at-risk of de-compensating so case managers can follow-up with the patients and/or their physicians regarding next steps, including getting the patients to see their physician that same day. According to PNHS, preliminary results suggest that as a result of this activity, the estimated number of averted hospitalizations for heart failure patients has increased steadily over time.

In addition, clinical care processes have been redesigned for diabetes patients so physicians can treat patients based on today's test results, nurse case managers identify patients overdue for tests or who are not meeting their health goals and work with their physicians on next steps, and certified diabetes educators are available at the clinic via immediate referral to teach patients on how to administer insulin, read meters, use new medications, and coordinate follow-up care. According to PNHS, preliminary results are suggesting that nurse visits with diabetes patients have increased over time and more patients are receiving their required insulin treatments.

2. Transition Management

The Everett Clinic's (TEC's) primary goal is to improve care delivery for seniors through their senior care model that improves post-discharge and emergency room visit follow-up and promotes palliative care for qualifying seniors. Hospital patient coaches focus on improving follow-up care while the patient is hospitalized and an automatic encounter request system reminds primary care physicians to follow-up with recently hospitalized patients within five days of discharge. Palliative care is promoted through the presence of hospice nurses within primary care offices who also provide intense case management and end-of-life planning education. According to TEC's preliminary results, the implementation of the automatic encounter request system could show promise in improveing patient follow-up and decreasing the hospital readmission rate for its patients aged 65 and older. TEC has also indicated a favorable trend in inpatient admissions and believes that both proper follow-up and improved care coordination and palliative care have all contributed to these positive results.

2006 Oncology Demonstration Project

CMS worked closely with the American Society for Clinical Oncology, the National Comprehensive Cancer Network and the National Coalition for Cancer Survivorship to develop a demonstration project that would assess oncologists' adherence to evidence based standards as part of routine care. The categories of data collected include:

- the primary focus of the evaluation and management (E&M) visit;
- whether current management adheres to clinical guidelines; and
- the current disease state.

Participating oncologists and hematologists qualify for additional payments if they submit data from each of the three categories when they bill for an evaluation and management (E&M) visit of level 2, 3, 4, or 5 for established patients. Physicians reporting data on all three categories qualify for an additional payment of $23 in addition to the E&M visit. The results will be closely analyzed by CMS.

The evaluation will use a combination of quantitative and qualitative methods to examine the impact of the demonstration on:

- Medicare spending;
- beneficiary outcomes;
- physician practice adherence to clinical guidelines; and
- financial status of physicians' practice.

In addition, through field assessments and physician surveys, the evaluation will examine how the demonstration impacted the way physicians delivered care to beneficiaries, and the types of modifications they needed to make in order to be able to report the data. The evaluation will include a validation study of physician-reported adherence to guidelines (American Society of Clinical Oncology guidelines and National Comprehensive Cancer Network guidelines).

The evaluation of the 2006 demonstration is being managed jointly by CMS' Office of Research, Development and Information (ORDI) and the National Cancer Institute (NCI).

Contractor bids have been submitted for the evaluation and an award is expected to be made by fall 2006. The demonstration is scheduled to be completed at the end of 2006.

Value-Based Purchasing (VBP) and the Private Sector

Ambulatory Quality Alliance (AQA) and Hospital Quality Alliance (HQA) Efforts

Part of an effective value-based purchasing system is provision of information to the public and healthcare purchasers so that patients can make informed decisions about which providers they seek care from. The AQA and the HQA are both organizations made up of a broad cross section of stakeholders (including CMS) that have focused their efforts on improving care by collecting data on agreed upon quality measures in their respective settings, and then making that information available to consumers, payers and health care professionals. The AQA recently announced a number of pilot programs charged with the responsibility of identifying, collecting and reporting data on the quality of physician performance across care settings. The HQA has been reporting meaningful and useful information on the quality of heart attack, heart failure and pneumonia care to patients in more than 4,000 of the nation's hospitals since April 2005 and recently expanded that data set to include information on surgical site infections.

The two organizations recently announced a joint committee to help coordinate some of their efforts. As a first step, they will coordinate and expand several ongoing pilot projects that are designed to combine public and private information to measure and report on performance in a way that is fully transparent and meaningful to all stakeholders. These sorts of efforts are the kind of thing we need to move us to an environment where physicians and other providers are acclimated to the idea that quality measures are important, that they can help them provide the best care to their patients and at the same time, reward them for doing so. That is a fundamental shift away from the way Medicare currently pays physicians.

Integrated Healthcare Association

Value-based purchasing is a concept being tested in the private market as well. For example, the Integrated Healthcare Association (IHA), an organization made up of health

plans, physician groups, and healthcare systems, plus academic, consumer, purchaser, and pharmaceutical representatives all in California have been working for several years now to promote the use and reporting of quality measures in physician practices in that state.

California's value-based purchasing program involves approximately 35,000 physicians in 211 physician organizations, who care for over 6 million individuals enrolled in seven major health plans (Aetna, Blue Shield, Blue Cross, CIGNA, Health Net, PacifiCare, and Western Health Advantage). Physicians are rewarded by the plans based on their physician group's performance in relation to clinical quality and patient satisfaction measures, and for investment in information technology.

Earlier this month, IHA announced that compared to 2004, physician groups participating in IHA's VBP program in 2005 reported that they screened about 60,000 more women for cervical cancer, tested nearly 12,000 more individuals for diabetes, and administered approximately 30,000 more childhood immunizations for their patients enrolled in HMO plans.

In addition to the across-the-board improvements on the evidence-based clinical measures, physician groups participating in the program increased their use of IT for such activities as prescribing, monitoring lab results, preventive and chronic care reminders, and electronic messaging. The percentage of physician groups achieving the maximum score for IT use increased by 11 percent in 2005. Prior year results showed that physician groups that received full credit on IT measures had average clinical scores that were significantly higher than those that showed little or no evidence of IT adoption.

Bridges to Excellence

The Bridges to Excellence program, a multi-state, multi-employer coalition developed by employers, physicians, plans, healthcare services researchers and other industry experts, and supported by the Robert Wood Johnson Foundation's Rewarding Results program is working to encourage significant leaps in the quality of care by recognizing and

rewarding health care providers who demonstrate that they deliver safe, timely, effective, efficient and patient-centered care.

This organization is offering participating physicians up to $50 per year for each patient covered by a participating employer or plan based on their implementation of specific processes to reduce errors and increase quality. In addition, a report card for each physicians' office describes its performance on the program measures and is made available to the public.

Physicians treating diabetics who meet certain high performance goals can receive up to $80 for each diabetic patient covered by a participating employer and plan. In addition, the program offers a suite of products and tools to help diabetic patients get engaged in their care, achieve better outcomes, and identify local physicians that meet the high performance measures. The cost to employers is no more than $175 per diabetic patient per year with savings of $350 per patient per year.

Physicians treating cardiac patients who meet established performance goals can receive up to $160 for each cardiac patient covered by a participating employer and plan. As with the diabetes program, cardiac Bridges to Excellence makes available a suite of products and tools to help cardiac patients get engaged in their care, achieve better outcomes, and identify local physicians who meet the high performance measures. The cost to employers is no more than $200 per cardiac patient per year with savings up to $390 per patient per year.

Rochester Individual Practice Association

Health plans are not the only organizations pushing VBP. Physicians have embraced this approach as well, because they recognize that it will reward them for what they want to do, which is provide the best care possible. The Rochester Individual Practice Association (RIPA), a physician-led IPA with over 3,000 participating physicians, 900 of whom are in primary care specialties, has been using VBP principles for several years now. The organization provides physicians' services to more than 300,000 Blue Cross

HMO members in upstate New York and its physicians are paid on a capitated basis by the plan.

Physicians in this organization pool a portion of the capitated payments they receive from the HMO. These funds are then reallocated based on the physicians' performance. A busy internist my contribute $15,000 and, depending on his/her performance, receive back between $7,500 and $22,500. RIPA measures patient satisfaction and compliance with a range of clinical standards. Physicians are sent an individualized report three times per year, comparing them to their colleagues. Their year end report includes payment based on how they performed and they are told at that time, how much more they would have earned, had they increased their performance by a given amount.

This approach has produced results. Just for example, RIPA reports that physicians succeeded in reducing the inappropriate use of antibiotics, which resulted in a yearly savings of over $1 million to the HMO. These savings were used to increase bonuses to the physicians. In addition, RIPA identified diabetes management and coronary artery disease patients in 2002 and trended their costs forward. They then compared these projected trends with their actual costs with a VBP program in place. It is notable that pharmacy costs increased due to more intense treatment, but in a very short time, costs for hospitalizations went down, which resulted in a multi-million dollar savings.

Conclusion

Mr. Chairman, thank you again for this opportunity to testify on physician payments within the Medicare program. We look forward to working with Congress and the medical community to develop a system that ensures appropriate payments for providers while also promoting the highest quality of care, without increasing overall Medicare costs. As a growing number of stakeholders now agree, we must increase our emphasis on payment based on improving quality and avoiding unnecessary costs. I would be happy to answer any of your questions.